## **Town of Manchester, Connecticut**

BENEFIT	High Deductible Health Plan/	BENEFIT	High Deductible Health Plan/
Costshares	Health Savings Account	Inpatient Hospital	Health Savings Account
	Deductible - \$2,000/\$4,000	General/Medical/Surgical/	Pre-cert only for Out-of-Network
	Coinsurance - 100% after plan deductible met	Maternity (Semi-private)	Covered 100% after plan deductible met
	\$4,000/\$8,000 out of pocket maximum		
		Ancillary Services	Covered 100% after plan deductible met
	Employer Contribution	Medication, Supplies	
	Employer Contribution \$1,000 single coverage	Psychiatric	Covered 100% after plan deductible met
	\$2,000 double or family coverage	rsychiatric	Unlimited days
	\$2,000 double of family coverage		Offinition days
		Substance Abuse/Detox	Covered 100% after plan deductible met
			Unlimited days
	Lifetime Maximum In-Network - Unlimited	Skilled Nursing/Rehabilitation	Covered 100% after plan deductible met
	Lifetime Maximum Out-Of-Network - Unlimited	Facility	Covered up to 180 days per calendar year
			0 14000/ 6 1 1 1 1 1 1 1
Preventive Care	Covered	Hospice	Covered 100% after plan deductible met
Pediatric	Covered		
		Outpatient Hospital	
Adult	Covered	Outpatient Surgery	Covered 100% after plan deductible met
, rout	557.50	Facility Charges	(Prior Authorization Required)
			, , , , , , , , , , , , , , , , , , , ,
Hearing	Covered	Diagnostic Lab & X-ray	Covered 100% after plan deductible met
	Screening part of physical exam		
Gynecological	Covered	Pre-Admission Testing	Covered 100% after plan deductible met
Madiaal Cambiaa		Other Complete	
Medical Services	Covered 100% after plan deductible met	Other Services	Caused 1000/ often plan deductible met
Medical Office Visit	Covered 100% after plan deductible met	Durable Medical Equipment	Covered 100% after plan deductible met
Outpatient PT/OT/ST/Chiro.	Covered 100% after plan deductible met	Prosthetics	Covered 100% after plan deductible met
	60 Combined Days	110001000	COVOICE TOO ACCUPANT GOODS INC.
	per calendar year per member		
		Home Health Care	Covered 100% after plan deductible met
Allergy Services	Covered 100% after plan deductible met		Unlimited days
			(Prior Authorization Required)
		Vision	Covered 100% after plan deductible met
Diagnostic Lab & X-ray	Covered 100% after plan deductible met		Covered once every 24 months
		December 1	Coursed 1000/ often both along deductible and
Innationt Madical Cambasa	Caused 1000/ often plan deductible met	Prescriptions (Coverage through Cigns)	Covered 100% after both plan deductible and
Inpatient Medical Services	Covered 100% after plan deductible met	(Coverage through Cigna)	applicable Rx copays \$5/\$10/\$20 are met
			Three Tier Formulary RX Rider
Surgery Fees	Covered 100% after plan deductible met		Three Her Formulary IXX Rider
Surgery rees	covered 100% after plan deductible met	* All benefits listed are for In-Network. For Out-of-Network benefits,	
		please refer to your Employee Benefit Summary.	
Office Surgery	Covered 100% after plan deductible met	, service serv	
		** Plan is Non-Gatekeeper. No referrals are required. No primary	
		care physician is required.	
Outpatient MH/SA	Covered 100% after plan deductible met		
		INFERTILITY: Coverage is subje	ect to a \$5,000 lifetime maximum
		F1 16	
Emergency Care Emergency Room	Covered 1000/ after plan dedicatible met	ELIGIBILITY: Dependent children to age 25; effective July 1, 2010	
	Covered 100% after plan deductible met	dependent children covered to age 26 for medical and prescription plans due to the passing of the Health Care Reform Act of	
		March 30, 2010.	Teatti Care Reluitii Act Ui
Urgent Care	Covered 100% after plan deductible met	Wici CT 30, 2010.	
organic dure	Sovered 10070 diter plan deductible filet		
Ambulance	Covered 100% after plan deductible met		
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